MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

October 17, 2014

David Seltz, Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

re: Annual Cost Trends Hearings

Dear Director Seltz:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 health plans that provide coverage to approximately 2.6 million Massachusetts residents, I want to thank you, your staff and your Board for your thoughtful and thorough work since the inception of the Health Policy Commission.

I am writing today to offer written comments on the Health Policy Commission's 2014 annual cost trends hearings. We appreciated the opportunity to testify at the October 7th hearing and commend you for conducting a series of important discussions throughout the two-day hearings that will help us as we work to attain the goal of cost containment.

While there have been many changes in the Massachusetts marketplace, controlling health care costs and keeping health care affordable remains the top priority and challenge facing all of us in the health care system. MAHP and its member plans have been strong proponents of the cost trends hearings as they are essential to shining a spotlight on underlying health care costs and holding the entire system accountable. Below are our written comments as a follow up to our oral testimony on October 7th.

The Country's Top Rate Health Plans & Focus on Cost Containment

Our member health plans continually set the standard for the rest of the country for clinical quality and member satisfaction with innovative programs designed to improve quality and coordinate care, integrating medical care, behavioral health and substance abuse services, and pharmacy benefits to meet the specific needs of their members. In its recent annual report ranking the clinical quality and member satisfaction of health plans, the National Committee for Quality Assurance's (NCQA) Insurance Plan Rakings 2014-2015 recognized the high performance of the Commonwealth's health plans as Massachusetts was again home to the nation's best commercial health plans, including the top HMO and PPO plans, as well as the country's top four (4) Medicaid health plans. These rankings include not only an analysis of health plan quality metrics but also include member satisifaction scoring as reported by the members themselves.

In addition to their commitment to quality, our member health plans have been committed to lowering health care costs as demonstrated in the Center for Health Information and Analysis' recent 2014 Annual Report on the Performance of the Massachusetts Health Care System. As the Center's

report showed, our member health plans' annual increases from 2012-2013 were well below the Commonwealth's 3.6 percent health care cost growth benchmark and our member health plans have made significant strides to contain health care costs for employers and consumers.

Focus on Provider Consolidation

Over the past six years (from 2008 to 2013), nearly two dozen state reports have examined health care costs and cost drivers. These reports represent some of the most comprehensive analysis on market trends and health care cost drivers anywhere in the country, with each report utilizing the most recently available data at that time.

Earlier this year, we asked Freedman HealthCare to examine the reports issued by Attorney General Martha Coakley, the Health Policy Commission, the Center for Health Information and Analysis (CHIA), CHIA's predecessor the Division of Health Care Finance and Policy, and the Division of Insurance to identify any recurring themes that appeared in at least three or more reports published over the six year period. Their conclusion: provider prices remain the most significant factor driving health care costs. The Freedman Report is attached for your review.

Health insurance premiums and medical costs are inextricably linked. Dealing with the underlying cost of care is essential to making health care affordable for employers and consumers and meeting the cost benchmarks included in the Payment Reform Law.

The changes taking place today will reshape the health care system for years to come. Some have suggested that the wave of mergers, acquisitions and clinical affiliations among hospitals, physicians and other providers is necessary and will result in better integration and improved quality for patients. However, there is a growing body of research among policy experts that shows greater consolidation does not, in fact, lead to better care and lower prices, but leads to enhanced bargaining power (and higher costs) with no notable improvement in quality of care for patients.

Over the last two years, nearly three dozen material change notices, most of which related to mergers, acquisitions and clinical affiliations among providers, have been filed with the Commission, resulting in three cost and market impact reviews. Ensuring a robust process for measuring and monitoring the changes in the marketplace is essential, particularly where such changes may reduce access to lower-cost options for consumers and undermine efforts to promote value-based decisions by purchasers.

A year ago, we outlined a series of measures that the Commission should adopt when reviewing and monitoring provider consolidation and appreciate the level of detail and the data that the Commission is requiring applicants to submit in their notice of material changes.

We would again urge that as part of these annual hearings, the Commission should review the status of the mergers, acquisitions and clinical affiliations the Commission has approved or chosen not to review. This annual review should be used to determine whether the benefits providers have promised in moving forward with their transactions, such as lower costs, better integration or improved quality, actually are occurring in the marketplace. Providers that fail to make good on the benefits they promised should be subject to enhanced review. Failing to closely monitor these transactions could have the impact of providers creating enhanced market power and greater price disparities and leaving consumers with higher prices and no notable improvement in quality in care.

Impact of the Substance Abuse Law on Evidence-Based Care & the Cost Benchmark

We share the concerns about the impact opioid addiction is having on Massachusetts families and our member health plans are committed to ensuring that all residents of the Commonwealth who need substance abuse treatment have access to it. We were proud to serve on the Opioid Task Force, which offered a balanced set of thoughtful approaches for addressing the full spectrum of this crisis.

While Chapter 258 of the Acts of 2014 includes a number of important tools to begin to address the ongoing opioid crisis, we remain extremely concerned that the law puts into statute standards that are inconsistent with nationally accepted criteria for treatment of opioid addiction and takes away important tools used to ensure that the right care is delivered at the right time and in the right setting, The removal of prior authorization for any admission and restrictions around utilization management are an especially troubling precedent as we work to encourage providers to move to global payments and appropriate, value based care.

Chapter 258 charges the Health Policy Commission with issuing a report by next May that would provide recommendations for policies intended to ensure access to and coverage for substance use disorder treatment throughout the Commonwealth. In that report, it would be important to compare the length of stay mandate with national, evidence-based best practice standards, so that care is delivered in an efficient and effective manner. Further, it is important that the HPC reaffirm use of managed care techiniques to help ensure evidence based care, so long as those techniques are consistent with MGL Chapter 176O and regulations arising therefrom.

Concerns with Increasing Rx Costs

Additionally, as part of this year's cost report, we would encourage the Commission to look at the impact of increases in prescription drug spending. While some segments of prescription drug spending have slowed, the cost of specialty drugs has risen significantly. PricewaterhouseCoopers's Health Research Institute June 2014 medical cost trend report estimates that while only four percent of patients use specialty drugs, those medications account for 25 percent of total drug spending nationwide.

While such therapies offer tremendous clinical benefits for patients, the immediate impact of — and broad demand for — these expensive drugs have led to increases in pharmacy costs at a much higher rate than previously anticipated. For example, MAHP's Medicaid health plans, as a group, have paid out roughly $60 million on Sovaldi-related claims for rate year 2014. Much of this expense was unanticipated due to the high cost and high demand for this drug. It would be important for the Commission to examine these costs to determine what impact increases in prescription drug spending will have on the Commonwealth's ability to meet the cost benchmark and threaten our cost containment goals, and whether the state has a role in engaging with plans and providers to analyze comparative effectiveness techniques and best practices for utilization of emerging high cost drugs and technologies.

Behavioral Health

MAHP and our member health plans place a high priority on providing access to high quality and necessary mental health services and on ensuring compliance with state and federal mental health parity laws. We have long supported the work of the Attorney General in studying and reporting on health care spending in the Commonwealth and we are pleased to see that she has initiated a review of spending on behavioral health. We are currently reviewing the Attorney General's report that was presented at the hearing. Our initial analysis of the report has raised some important issues. More specifically, we feel it is premature to draw conclusions on the data in the report, because, as the Attorney General's staff stated during their presentation, it is

difficult to compare behavioral health spending, because there are both differing definitions of behavioral health care services and differing methodologies for reporting across the entities and programs analyzed. In addition, the study is not risk adjusted and does not address the differences in the acuity of the Medicaid population as compared to the commercial population. In comparison to the general population, Medicaid beneficiaries have much higher rates of poor health, fewer resources, and lower rates of health literacy. It will be important, going forward, for the Attorney General's Office as well as the HPC to do a deeper dive into the data to understand behavioral health care spending, utilization and access trends.

However, we feel that this report is a good start to addressing the behavioral health issue and we look forward to further study and analysis so that we can have an informed data-driven conversation. There are several other studies currently in progress and MAHP is also participating in several commissions which are exploring behavioral health issues as well as in Division of Insurance listening sessions concerning behavioral health. MAHP and our member health plans will continue to advocate for transparency and behavioral health integration and are committed to working with others in the health care industry to address these issues.

Limited and Tiered Networks

As you are aware, health plans operating in Massachusetts are mandated to offer limited and tiered network plans at a significant premium discount. MAHP has supported the development of limited and tiered network products as a measure to control cost and quality in the health care system for individuals and businesses in Massachusetts. With the prevalence of wide price disparities in the health care market, these products allow consumers and employers the choice of selecting lower cost providers in order to keep their health care costs down while ensuring the availability of high quality services. The Division of Insurance determines network adequacy for a tiered or limited network plan based on the availability of sufficient providers in the carrier's overall network of providers, with consideration given to explicit factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the plan, and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network. Network adequacy for plans operating in Massachusetts is also confirmed by regular reviews conducted by national accreditation organizations such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) as part of each plan's accreditation process. Health plans also apply internal network adequacy standards to achieve the primary goal of ensuring that individuals enrolled in all products are able to receive medically necessary care in the most appropriate setting while keeping monthly premiums at a minimum. By establishing a limited or tiered network through selective contracting with well-credentialed providers, health plans are able to effectively control the cost and quality of services provided to their members. These products provide consumers and employers a lower cost option for their health care coverage and are essential to the Commonwealth's efforts to provide high quality affordable care to Massachusetts citizens.

Ensuring Employer & Consumer Choice

Finally, with regard to the movement towards PPO and self-insured coverage options, it is important to remember that employers' and individuals' needs vary and that they are increasingly moving toward products with broad choice in network providers.

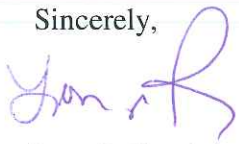
Among the reasons employers often cite for choosing a PPO is that these plans allow them to offer their employees an open choice of providers. This is particularly useful when employees work for several days or weeks out-of-state or are physically located in other states. This is also important for the employees' dependents who may live out-of-state and cannot easily use a network with Massachusetts-only providers. Likewise, among the reasons that employers give for moving to self-insured coverage is that it provides them with greater flexibility and choice in benefit design and, for some employers, allows them to avoid covering certain mandated benefits or to place limits on them.

While we recognize that coverage options that offer broad choice may raise concerns with providers, as you heard at the hearing, health plans have been working with providers in developing methodologies to attribute patients to a PCP, which will help further the adoption of alternative payment methods for PPO members where it makes sense for health plans and providers.

These hearings are an important opportunity for the Commission to take a closer look at the changes taking place in the Commonwealth, and to ask important questions about the impact changes in the marketplace will have on employers, on consumers, and on the cost of health care.

We appreciate the opportunity to offer our comments and we look forward to the Commission's final report.

Sincerely,



Lora Pellegrini
President & CEO

cc: Stuart Altman, Ph.D., Chairman, Health Policy Commission
Wendy Everett, Sc.D., President of NEHI, Vice Chair, Health Policy Commission
Carole Allen, M.D.
David Cutler, Ph.D., Otto Eckstein Professor of Applied Economics, Department of Economics, Harvard University
Paul Hattis, M.D., J.D., M.P.H., Senior Associate Director of the MPH Program, Tufts University School of Medicine
Richard C. Lord, President & CEO, Associated Industries of Massachusetts
John Polanowicz, Secretary, Executive Office of Health and Human Services
Glen Shor, Secretary, Executive Office for Administration and Finance
Marylou Sudders, M.S.W., Associate Professor of Macro Practice and Chair, Health & Mental Health, Boston College Graduate School of Social Work
Veronica Turner, Executive Vice President, 1199SEIU
Jean Yang, Executive Director, Commonwealth Health Insurance Connector Authority